

**Application for Financial Assistance**

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MEDICAL RECORD NUMBER:** \_\_\_\_\_

Please answer all questions as completely and as accurately as possible. If you do not have enough space for your answer, attach another sheet of paper to this application.

**Please list everyone in your home including the patient and complete each space by their name:**

<b>Social Security Number</b>	<b>Last Name</b>	<b>First Name</b>	<b>Birth Date</b>	<b>Relationship to you</b>	<b>Employer</b>

**INCOME: DOES ANYONE IN YOUR HOME INCLUDING THE PATIENT HAVE INCOME FROM THE FOLLOWING?:**

<b>Monthly Income</b> Please Circle Yes or No	<b>Name of Person's Receiving</b>	<b>How Often Received</b>	<b>Amount After Deductions</b>
<b>Employment/Work</b>	Yes No		
<b>Farming/Self-Employment</b>	Yes No		
<b>Rental of Property</b>	Yes No		
<b>Retirement Benefits</b>	Yes No		
<b>Social Security Benefits</b>	Yes No		
<b>Supplemental Security SSI</b>	Yes No		
<b>Veteran's/ Other Pensions</b>	Yes No		
<b>Serviceman's Allotments</b>	Yes No		
<b>Job Corps Allotments</b>	Yes No		
<b>Child Support/Alimony</b>	Yes No		
<b>Contributions/Family Friends</b>	Yes No		
<b>Unemployment Benefits</b>	Yes No		
<b>Worker's Compensation</b>	Yes No		
<b>Student Loans, Grants</b>	Yes No		
<b>Roomers or Boarders</b>	Yes No		
<b>Insurance</b>	Yes No		
<b>Savings or Dividends</b>	Yes No		
<b>Other (Babysitting, Part-time Work)</b>	Yes No		

**TOTAL MONTHLY INCOME \$** \_\_\_\_\_

**PROOF OF MONTHLY INCOME AND CURRENT BANK STATEMENTS REQUIRED**  
 Paycheck stubs, copy of monthly benefit checks, award letters, employer wage letter, etc.

## Application for Charity Care

File Income Tax      (Yes) Attach a copy of your current 1040 Federal Income Tax Documents.

File Income Tax      (No) Explain: \_\_\_\_\_

If you work      (Yes) and do not make enough to file Income Tax, attach a copy of your W-2 Forms.

Have Checking account      (Yes)      (No) If you marked (Yes), attach a current copy of your Bank Statement.

Have Savings account      (Yes)      (No) If you marked (Yes), attach a current copy of your Savings Statement.

Receive Public Assistance      (Yes)      (No) If (Yes), attach proof of Food Stamps & HUD.

HUD \$ \_\_\_\_\_ Per Month

Food Stamps \$ \_\_\_\_\_ Per Month

Has anyone in your home worked in the last 6 months who is not working now? If yes, list their name, the last month/year in which the person worked, and the place they worked \_\_\_\_\_

How have you been meeting your expenses for the past 6 months? \_\_\_\_\_

**MONTHLY EXPENSES:**

Monthly House or Rent Payment.....	\$ _____
Monthly Car or Truck Payments.....	\$ _____
Monthly Bank Loan Payments.....	\$ _____
Monthly Credit Card Payments (List minimum amount payable per month).....	\$ _____
Monthly Doctor, Dentist, or Hospital Payments.....	\$ _____
Monthly Utilities (Electric, Gas, Water, Telephone, Cable, Etc.).....	\$ _____
Monthly Food, Clothing, Car Fuel Donations.....	\$ _____
Monthly Student Loan Payments.....	\$ _____
Monthly Child Day Care Payment.....	\$ _____
Monthly Child Support Payment.....	\$ _____
Monthly Medicine (Amount not paid by Health Insurance Plans).....	\$ _____
Insurance Premiums paid every month (Not paid through check deductions).....	\$ _____
Insurance Paid every 3 months.....\$ _____	\$ _____
Insurance Paid every 6 months.....\$ _____	\$ _____
Insurance Paid every 12 months.....\$ _____	\$ _____
Personal & Real Estate Tax per year..\$ _____	\$ _____

**TOTAL MONTHLY EXPENSES**.....\$

**Please Read Before Signing**

The information on this form is for the purpose of considering charity care. I certify that the information furnished is true and accurate to the best of my knowledge. I authorize St. Bernards Regional Medical Center, its agent or any Credit Bureau or other Investigative Agency employed by St. Bernards to investigate the references herein listed, statements made, or other data obtained from me pertaining to my credit and financial responsibility. St. Bernards reserves the right to request verification or to adjust monthly living expenses for reasonableness. Applications cannot be processed without proof of income documents and will be returned to you.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number (Where you can be reached).....Area Code \_\_\_\_\_ Number \_\_\_\_\_

Mailing

Address: \_\_\_\_\_

(Street or Post Office)

(City)

(State)

(Zip Code)

